

Vermont Blueprint for Health

Vermont's Chronic Care Initiative

Background

Chronic conditions¹ are the leading cause of illness, disability and death, touching the lives of most Vermonters and consuming more than three-quarters of the \$2.8 billion we spend each year on health care.²

More than half of all Vermont adults have one or more health care problems that can be expected to last a year or longer, limit what they can do, and/or require ongoing medical care.

The number of Vermont adults reporting chronic conditions increases with age: in a recent survey, 88 percent of those age 65 and older reported having one or more chronic conditions and 20 percent reported having four or more.

Nationally, care for people with chronic conditions currently represents

- 83 percent of health care spending,
- 81 percent of hospital admissions,
- 76 percent of all physician visits, and
- 91 percent of prescriptions written.³

The needs of people with chronic conditions will be the primary driver of demand for health care and the resulting costs for the foreseeable future. With the aging of the baby boomers, the impact of chronic conditions will grow and, with it, the imperative to improve peoples' lives and contain costs.

Vermont's response to the challenge of chronic conditions is embodied in the Vermont Blueprint for Health, a collaborative project begun in the fall of 2003 and led by a public-private partnership that includes state government, health insurance plans, business and community leaders, health care providers, and consumers.

The Vermont Blueprint is based in large part on a chronic care model that has been developed by an organization called Improving Chronic Illness Care (ICIC).⁴ Based on an analysis of available literature about promising strategies for chronic illness management, the ICIC model

¹ "Chronic conditions," as used here, has a broader meaning than "chronic disease." It is a general term that includes chronic illnesses and impairments that are expected to last a year or longer, limit what one can do, and/or may require ongoing medical care.

² In Vermont, it is estimated that in excess of \$2.2 billion is spent each year on chronic conditions, including approximately \$550 million in Medicaid spending.

³ Medical Expenditure Panel Survey, 2001, cited in Chronic Conditions: Making the Case for Ongoing Care, September 2004 Update, a chartbook published by Partnership for Solutions: Johns Hopkins University and The Robert Wood Johnson Foundation (www.partnershipforsolutions.org).

⁴ <http://www.improvingchroniccare.org/>

envisioning an informed, activated patient interacting with a prepared, proactive practice team, resulting in high quality encounters and improved health outcomes. It includes roles for the community, the health care system and the health care practice team, and it addresses the issues of self-management support, delivery system design, and clinical information and decision support systems. The ICIC premise is that the evidence-based change concepts that are associated with each of these elements will, in combination, foster productive interactions between informed patients who take an active part in their care and providers who have the benefit of appropriate resources and expertise.

The Vermont Blueprint is actively pursuing change in four broad areas: patient self-management, provider practice change, community development and information system development.

Patient Self-Management: Effective chronic disease management is best achieved when the patient actively manages his or her own care in collaboration with the primary care physician and other members of a health care team. Patients then have a central role in determining their care, one that fosters a sense of responsibility for their own health. The Blueprint self-management team is exploring evidence-based strategies to improve patient skills in self-care, and is currently piloting a chronic disease self-management course.⁵

Provider Practice Change: The Blueprint provider practice team is addressing the three areas of the ICIC Chronic Care Model that are central to ensuring that providers are proactive and prepared to deliver needed chronic care services. These areas are delivery system design, decision support and the use of a patient registry (clinical information system).

In a well-designed delivery system, clinicians plan visits well in advance, based on the patient's needs and self-management goals. All of the clinicians who take care of a patient have centralized, up-to-date information about the patient's status, and follow-up is a part of standard procedure. Treatment decisions need to be based on evidence-based practices, and evidence-based guidelines are integrated into the day-to-day practice of the primary care providers in an accessible and easy-to-use manner. A key laboratory for testing ways to improve this design is the Vermont Community Diabetes Collaborative, run by the Vermont Program for Quality in Health Care and funded by the Department of Health and other state resources.

Community Development: Community participation in the management of chronic conditions is a new concept, yet there are numerous existing community services that can and do support people with chronic conditions. Because physical activity is a key management strategy that is easily understood and implemented by communities, the Blueprint community team is focusing on expanding physical activity services.

⁵ [Hhttp://patienteducation.stanford.edu/programs/cdsmp.html](http://patienteducation.stanford.edu/programs/cdsmp.html)H

Information System Development: Effective chronic illness care is virtually impossible without information systems that assure ready access to key data on individual patients as well as on patient populations. A patient registry is the cornerstone of a comprehensive clinical information system that can enhance the care of individual patients by providing timely reminders about needed services and summarized data to track and plan care. At the practice population level, it is used to identify groups of patients needing additional care, as well as to facilitate performance monitoring and quality improvement efforts. Although the Blueprint health information system team has experienced initial difficulty in finding a suitable application, deployment of a practice registry that would interface with a growing comprehensive health information system is the team's priority project.

Pilot Communities: Test implementation of all Blueprint components are planned for communities in Southwestern and Northeastern Vermont, to align and better understand support services that need to be in place to overcome barriers for change. Other communities and provider practices will have the opportunity to participate in individual Blueprint programs.

The pilot communities are the towns served by Northern Counties Health Care and the Northeast Vermont Regional Hospital, in the St. Johnsbury area, and those served by Southwestern Vermont Health Care, in the Bennington County area. The Blueprint will give these areas access to:

- Vermont Community Diabetes Collaborative — training and support for office practice redesign, including assistance to implement a clinical information system, to support higher quality care. (Offered by the Vermont Program for Quality in Health Care, with support from VDH and BISHCA.)
- Self-care Management Program — training and stipends for group leaders, course materials for participants.
- Mini-grants to develop or enhance resources for physical activity.
- Priority for other VDH grant support when projects are related to the Blueprint, such as the federal Rural Hospital Flexibility program for small hospitals, and the Fit & Healthy Kids program.